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FROM THE ACC

President's Page: The State of Cardiology Is Sound

A President's Perspective on Leaving Office

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"We understand that greatness is never a given. It must be earned.
Our journey has never been one of shortcuts or settling for less.
It has not been the path for the fainthearted . . ."
—President Barack Obama's January 2009 inaugural address (1)

The past year has been a challenging one for medical professional societies like the American College of Cardiology (ACC), particularly as a result of health care reform and an increased focus on cutting costs as a result of the economic downturn. It certainly has not been for the "fainthearted."

When it comes to cardiology, no one has been immune to the changes. Private practices across the U.S. are making decisions on whether to integrate with hospitals or brave new business models, while academic medical centers are dealing with new research guidelines, dwindling funding sources, and a decreasing number of new recruits. New health care delivery and physician payment models have everyone scrambling to understand and plan for the inevitable transitions that will occur as we move away from a system focused on volume of services to one that is more focused on quality and outcomes.

The need for the ACC's leadership, direction, and guidance has never been more critical. Ask any of the College's governors and they will tell you that cardiovascular specialists have become targets by the very virtue that cardiovascular disease represents 43% of Medicare costs (2). With the country's appropriate need to "bend the cost curve," we are consistently singled out when there are discussions of waste or inappropriate use of tests or procedures. We also are seeing ever-increasing demands for quality measurement and assessment, public reporting, maintenance of certification, and adoption of health information technology (IT). These aforementioned concepts are clearly appropriate as health care redesign becomes increasingly important, but they also require the active engagement of the medical profession to ensure wise implementation without negative unintended consequences in patient care.

Because of these attacks on our profession, I chose "professionalism" as the theme for my presidential year. I felt a strong need to prove to ourselves and our critics that we are more than a guild looking out for its own interests, but rather a true profession that values the work we do and the care we provide to our patients over anything else. My focus was three-fold: 1) demonstrate professional competence and a commitment to ensuring patient access to high-quality, appropriate care; 2) be honest with patients and maintain trust by effectively managing conflicts of interest, including an increased commitment to transparency; and 3) demonstrate our scientific knowledge and have the courage to lead and even take a public stance on issues and policies that affected our patients.

As I prepare to pass the presidential gavel, I am proud to say that ACC leaders and our members have truly risen to the occasion. I believe we have made substantial inroads in promoting the ACC as a profession, and these efforts have been consistently recog-

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nized by the White House, Congress, the Centers for Medicare and Medicaid Services, the National Institute of Health, the Agency of Health Research and Quality, the Food and Drug Administration (FDA), our partners in the medical community, and even those in the payer community, along with a myriad of patient advocacy groups. We are viewed by many as a forward-thinking professional society and a trusted resource when it comes to cardiovascular science and educational expertise. We are also increasingly the go-to organization for issues involving assessment of quality and appropriateness of cardiovascular care and new care delivery and payment models.

Over the last year we have taken a stand on health care reform and stood by the principles developed under the leadership of our friend and late colleague, James Dove, MD, FACC (3):

- Universal coverage;
- Coverage through an expansion of public and private programs;
- Focus on patient value—transparent, high-quality, cost-effective, continuous care;
- Professionalism, the foundation of an effective partnership with empowered patients;
- Coordination across sources and sites of care; and
- Payment reforms that reward quality and ensure value.

While we did not win every battle, we were successful in including several of these principles in the final health reform bill. At the same time, we also helped defeat several harmful policy concepts, including: separate, service-based conversion factors; prior authorization of imaging services by radiology benefit management companies (RBMs); and limits on self-referral.

Other successes included the passage of a 12-month patch to the flawed sustainable growth rate formula, as well as the introduction of two separate bills by Rep. Charles Gonzalez (D-Texas) aimed at minimizing the impacts of the 2010 Medicare Physician Fee Schedule cuts and legislating phase-ins of future cuts. This could not have happened without the strength and support of ACC members, including those that contributed more than $1 million over the last election cycle to the College's Political Action Committee and those who took time out of their busy schedules to take part in the largest-ever Legislative Conference in Washington, DC.

We have also made significant inroads when it comes to improving the care we provide to all of our patients. We have strengthened working relationships with the FDA on radiation safety and drug/device safety alerts, and we may soon be the convening group for the FDA, industry, and academics in pursuing tactics for accelerating diffusion of cardiovascular innovation into the marketplace. We also have armed cardiovascular professionals with tools and resources to reduce racial disparities through the launch of the Coalition to Reduce Disparities in CV Care (*credo*). In addition, the ACC has added a number of important partners as part of the CardioSmart national care initiative—allowing us to reach a broader swath of the public and to provide important information on prevention and treatment of heart disease.

The Cardiovascular Leadership Institute (CLI) is also growing quickly, with the goal of training the next generation of leaders and providing tools and resources for cardiovascular professionals to effectively advocate for their patients in this time of rapid change. The CLI will help fill the perceived void in physician leadership, now particularly needed with the increasing mergers of private practices into hospital systems.

The College's quality improvement initiatives like Hospital to Home, Imaging in FOCUS, and the PINNACLE Network continue to bring together cardiovascular professionals to share best practices as they relate to reducing hospital readmissions, ensuring appropriate imaging, and helping practices navigate the changing health care environment. The PINNACLE Registry has also taken off, surpassing more than 1.5 million patient records. Discussions continue with health plans on the application and use of the PINNACLE Registry and other National Cardiovascular Data Registry (NCDR) registries as a means of reporting and measuring quality that does not involve relying solely on administrative claims data. To date, the NCDR registry suite has grown to six registries representing 11 million patient records, 2,500 hospitals, and a $23 million/year investment offering modest revenue generation for the College. The College also is working with several health plans on adoption of an ACC-sponsored alternative to RBMs called Cardiovascular Imaging Strategies. This product offers a performance-based, transparent, and accountable solution to ensuring appropriate imaging.

Some issues from this past year need special mention, including accusations of overuse of coronary stenting procedures and an article in the *Journal of the American Medical Association (JAMA)* that raised national concerns of inappropriate implantable cardioverter-defibrillator (ICD) implantation for primary prevention in 23% of the implants in the Medicare population (4). Both cases presented opportunities to illustrate how professional societies can take a leadership role in ensuring

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quality care in the areas of peer review, accreditation, and data management.

Inaccurate and disingenuous reporting from the Dr. Oz show this year (5), along with alleged inappropriate percutaneous coronary interventions by an interventionalist in the state of Maryland (6) gained the attention of media and the public nationwide. The ACC's Maryland Chapter and the Society for Cardiovascular Angiography and Interventions (SCAI) worked with the Maryland state legislature to offer comprehensive infrastructure tools for proper evaluation of catheterization laboratory quality, even helping craft legislation requiring quality catheterization laboratory oversight. The Maryland proposal includes oversight of hospital peer review through the Accreditation for Cardiovascular Excellence program, a partnership between the ACC and SCAI.

The *JAMA* article on ICDs also served as a lightning rod. Although some well-founded criticisms have been leveled at the *JAMA* study, we should all take particular pride in the ICD study and in the ICD Registry itself. These efforts define in many ways why we are a profession and not a guild. The ACC and the Heart Rhythm Society are actively providing the measurement tools, such as the NCDR ICD Registry, to help clinicians and hospitals deliver high-quality and appropriate care. Inappropriate use of ICD implantation increases the cost of health care and places our patients at risk for procedural complications. By using the ICD Registry to evaluate physician practice, we gain greater understanding about practice patterns, expand our evidence base, and determine how practice guidelines are implemented in clinical practice. This important study also indicates that there are substantial variations among hospital ICD implantation strategies. We are optimistic that feedback and education to hospitals and clinicians about this important data will change practice patterns to the benefit of our patients.

Already in 2011 we have hit the ground running in terms of identifying payment reform, delivery system reform, tort reform, and health IT implementation as priorities for the year. The ACC has taken a leadership role in building consensus among various medical specialties as to physician payment reform and is working to educate cardiovascular professionals about important regulatory issues like new imaging laboratory accreditation requirements, continued coding changes as the result of bundling, preparation for the ICD-10 coding transition, and Physician Quality Reporting System participation. On the science and education front, the NCDR just announced its first international partnership with the United Arab Emirates, and the College's 60th Annual Scientific Session will be the most innovative and cutting-edge to date. We are rising to the occasion as "knights of cardiology," and we are proving to the world that we will not stand by and be pawns or knaves. We are quality in action.

As I look back over this past year, I am proud of all of the great things we have done (and continue to do) as a profession to ensure that our patients are getting the best care at both the national and international level. Whether it is through registries, clinical documents, relationships with lawmakers, or educational programs, we are making a difference and paving the way for future generations of cardiovascular professionals and saving the lives of countless patients in the process. As I prepare to hand over the reins of the College to the capable hands of David Holmes, MD, FACC, I am confident in saying that the state of the cardiovascular "union," while under transition, is sound!

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